

HEALTH PLAN PARTNERS MEETING

SUMMARY NOTES

FRIDAY, NOVEMBER 21, 2003 · 12:30 – 2:00 P.M. · AGING & INDEPENDENCE SERVICES

I. Introductions

Diane Flanders – MassHealth Senior Care Options
Mark Meiners – Medicare/Medicaid Integration Program, Robert Wood Johnson Foundation
Evalyn Greb- Aging & Independence Services (AIS), LTCIP
Sara Barnett – AIS LTCIP
Tim Schwab – SCAN (Social HMO)
Julie Johnston – Evercare
John Pierce – Healthy San Diego (HSD)
Melissa Stout – Community Health Group (CHG)
Sophia Nguyen – St. Paul's Senior Homes & Services (PACE)
Leslie Hine-Rabichow – San Diego Association of Nonprofits (SANDAN)
Jeff Lazenby _Sharp Health Plan
Teresa Graves – Sharp Healthcare
Rogelio Lopez – HealthNet
John Polston – Universal Health Care
Christine Nelson – Blue Cross
Sandy Atkins – Center for Long Term Care Integration (USC)
Pat Sussman – Contra Costa Health Plan

II. Purpose of Meeting

The purpose of the meeting was to engage potential health plan partners for integrated care in a discussion with Diane Flanders about the newly authorized MassHealth SCO integration program as a potential (replicable) service delivery model for San Diego. The LTCIP Health Plan Workgroup no longer consists just of Healthy San Diego health plans, but includes an expanded group of parties and experts interested in participating in LTCIP under HSD expansion (HSD+). Audio recording of the meeting available at <http://www.hhp.umd.edu/AGING/MMIP/sandiegoflanders.HTML>

III. Group Discussion

The following questions, comments and statements were made during the group discussion:

- State requires that SCOs contract with Area Agencies on Aging (AAAs) for licensed social workers (Geriatric Support Services Coordinators or GSSCs) to join the primary care physician and nurse to form the care management team. SCOs and AAAs make decision about proper caseload for GSSCs based on need. Other states may choose to allow AAAs to partner with community-based case managers, if needed or desired. State involvement is not prescriptive, except for social work licensure; willing to be flexible as long as there is federal (CMS) buy-in.
- Enrollment will determine how many Geriatric Support Services Coordinators (GSSCs) are needed. In Massachusetts, dozens of primary care physicians (PCPs) are already part of the provider networks preparing to be SCOs. Physicians in every specialty area have already been identified, as well. Additional PCPs and specialists may be added to each SCO's roster, depending on the enrollment experience and enrollee preferences going forward. State is not placing a cap on enrollment, but is

projecting 300 enrollees per month for the first year (3600 by the end of year one). The State is not involved in determining number of PCPs, specialists or GSSCs.

- Break-even enrollment projected by the end of the second year, but actual enrollment distribution unknown.
- Most SCOs already have geriatric physicians affiliated with them, so not that difficult to get them involved.
- GSSCs are licensed social workers, not RNs. Decision was made based on lessons learned from other programs that experienced role confusion re duties/responsibilities between RN case managers and RNs that worked in the physician office.
- State does not require SCOs to contract with all traditional providers, but SCOs must demonstrate that they are able to provide the full range of Medicare and Medicaid services.
- Enrollee preference will ultimately determine which community-based organizations (CBOs) SCOs contract with; State not involved. AAAs can subcontract with CBOs for certain social services (i.e., AAA acts as administrative service organization for CBOs); SCOs may also contract directly with individual CBOs or a network of CBOs (outside of AAAs).
- Medicare+Choice Regional Office will conduct site reviews to make sure that SCOs meet all requirements, have proper certifications, etc.
- In MA, specialty mental health for Medicaid non-elderly (under 65) is carved out, but the SCO program provides mental health and substance abuse services for its target population (elderly 65+, Medicaid-only or dually eligible) .
- SCO program must be budget neutral (i.e., Medicaid must cost no more than it would have under FFS).
- The financial case for the program rests on bringing in Medicare dollars. Projected to bring in \$55 million in first year (assuming 3600 enrollees by end of first year).
- State projects savings after 5 years (3%).
- Electronic medical record (EMR) – each SCO is required to have a centralized enrollee record, and each has one or is developing one, but EMR is not required. State defined the process for SCOs regarding capabilities, capacity, accessibility of centralized enrollee record (e.g., each record must be available 24/7 to the on-call clinician).
- Prescription drugs - Current Medicaid pharmacy coverage lists are covered. If Medicare drug benefit passes, SCO Rx drug benefit will have to be adjusted.
- Exclusions: End stage renal disease (ESRD); undecided about transplants. However, costs of ESRD and transplants were factored into rate structure. Enrollee can also stay in SCO if develop ESRD while enrolled in program.

- Outreach will be performed by SCOs (under M+C rules), MassHealth (Medicaid) eligibility offices, and materials distributed and made available at community AAAs and other agencies.
- SCO model has the potential to work for San Diego LTCIP under AB1040 if use “phase-in” approach. Program would be voluntary given that Medicare enrollment cannot be mandated; doesn’t make sense to make Medi-Cal mandatory in the beginning and then have to change when bring in Medicare cap.
- Critical mass not as important if develop appropriate rates (SCO rating categories based on MDS for home care).
- MA used waiver service substitution exercise with 1915(C) HCBS and State Plan services to develop Medicaid rate. SCOs will offer the full range of home and community-based services (HCBS), but in developing the SCO capitation rate, 1915 (c) waiver services could not be used by CMS rules under the Balanced Budget Act. However, the State was allowed to substitute 1915(a) State Plan services and costs for equivalent HCBS (i.e., 1915 (c) waiver includes “social day care,” so “adult day health” was substituted into rate structure). In general, this substitution exercise allowed sufficient flexibility in SCO Medicaid rate to provide needed HCBS to enrollees.
- Side-by-side relationship between SCO and PACE: SCO will be in addition to PACE; SCO can purchase PACE enrollment. If a SCO enrollee determines that he/she should really be enrolled in PACE, he/she may disenroll in SCO and enroll in PACE.....and vice versa.
- If you want to enroll in SCO and meet age & Medicaid eligibility, and you agree to the terms in the Evidence of Coverage contract, SCO has to enroll you (initial assessment is included in the EOC, so refusal would mean that you did not agree to the terms and therefore had decided not to enroll.).
- Massachusetts Medicare rates:

Community Well –including Alzheimer’s Disease/Chronically Mentally Ill:	\$900 PMPM
Community Nursing Home Certifiable (NHC):	1750
Institutional – Nursing Home:	1400
- MassHealth (Medicaid) rates:

Community Well:	\$240 PMPM (per member per month)
Community AD/CMI:	520
Community NHC:	2380
Institutional Tier 1 – Low acuity NH resident:	3640
Institutional Tier 2 – Moderate acuity NH resident:	5200
Institutional Tier 3 – High acuity NH resident:	6370

IV. Adjourn Stay tuned for future meeting announcements

If you have questions or would like more information, please call (858) 495-5428 or email: evalyn.greb@sdcounty.ca.gov or sara.barnett@sdcounty.ca.gov